DEFENDANT'S EXHIBIT A-3

MEDICATION ADMINISTRATION RECORD

12/01/2003
STDT01

(ELM-454) E

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
HCTZ (HYDROCHLOROTHIAZIDE) 25MG TAB TAKE 1 TABLET(S) BY MOUTH IN THE MORNING *KEEP ON PERSON* RX: 4794157 SONNIER, M.D. (MD DI, MARC , MD START - 11/12/2003 STOP - 05/09/2004	
VERAPAMIL SR (CALAN SR) 240MG TAB TAKE 1 TABLET(S) BY MOUTH IN THE MORNING *KEEP ON PERSON* RX: 4794164 SONNIER, M.D. (MD DI, MARC , MD START - 11/12/2003 STOP - 05/09/2004	
GUAIFENESIN 200MG TAB TAKE 1 TABLET(S) BY MOUTH TWICE DAILY RX: 4794205 SONNIER, M.D. (MD DI, MARC , MD START - 11/12/2003 STOP - 12/11/2003	
ENALAPRIL (VASOTEC) 5MG TAB TAKE 1 TABLET(S) BY MOUTH DAILY *KEEP ON PERSON* RX: 4814706 SONNIER, M.D. (MD DI, MARC , MD START - 11/15/2003 STOP - 06/01/2004	
Flexaccare 0.5cc IM x 1 given 12-14-03 Dr Sonnier	

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 12/01/2003 THROUGH 12/31/2003

Physician SONNIER, M.D. (MD DI, MARC | Telephone No | Medical Record I

Alt Physician | Alt Telephone

Allergies NONE KNOWN | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked: By: Title: Date: 11/27

PATIENT PURTEDY, ANDRE | PATIENT CODE | ROOM NO | BED | FACI

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Robaxin 500mg – 1 PO BID X 10d 2/25/03 – 3/7/03	6 6 2 2 B B B B

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 3

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3/1/03 THROUGH 3/31/03

Physician Sommer

Alt. Physician

Telephone Number

Alt. Telephone

Inmate No. 182373

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: B Buckhalter Title: Date:

PATIENT Pugh Cedric

PATIENT CODE

ROOM NO.

BED

FACILITY CO See

MEDICATION ADMINISTRATION RECORD

NaphCare

MEDICATIONS	HOUR
Pen VK 500mg i po tid x 7d 6/17 - 6/24/n Mies	6 12 6
Flagyl 250mg i po tid x 7d. 6/17 - 6/24/n. Mies	6 12 6
Motrin 600mg i po tid x 7d 6/17 - 6/24/n Mies	6 12 6

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 6.1.01 THROUGH 6.31.01

Physician Taylor

Alt. Physician Mies

Telephone Number

Alt. Telephone

Inmate No. 182375

Allergies NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: [signature] Title: W Date: 6/17/01

PATIENT Pugh, Cedric

PATIENT CODE | ROOM NO | BED | FACILITY C see

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
[illegible] PO TID x 3 days [illegible]	0500 1100 1600													mepe No Dose R R R															
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4/11/06 THROUGH 4/[illegible]/06

Physician Fish

Alt. Physician

Telephone No

Alt. Telephone

Medical Record

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked: By: [illegible] LPN Title: Date: 4/11

PATIENT [illegible]

PATIENT CODE

ROOM NO

BED

FACI

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR
Pen VK 500 mg PO TID X 7 days 4/2/99 - 4/9/99 West	0500, 1100, 1600
Motrin 600mg PO BID x 3 days 4/2/99 - 4/5/99 West	0500, ~~1100~~, 1600

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4/2/99 THROUGH 4/30/99

Physician Fish

Alt. Physician West

Telephone No.

Alt. Telephone

Medical Record

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: J Payton RPh Title: Date: 4/2

PATIENT Pugh, Cedric

PATIENT CODE

ROOM NO

BED

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
[illegible]	4 AM																												
	9 AM																												
	1 PM																												
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR [illegible] THROUGH [illegible]

Physician [illegible]

Alt. Physician

Telephone No

Alt. Telephone

Medical Record N

Allergies

NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By:

Title:

Date:

PATIENT [illegible]

PATIENT CODE

ROOM NO

BED

FACILI

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
Advil 200mg PO TID x 7 days 5A 11A 5P 10-20-97 - 10-27-97 Dr. West	A A A A A A A X
Pen VK 500mg PO TID x 7 days 5A 11A 5P 10-20-97 - 10-27-97 Dr. West	A A A A A A A X

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR THROUGH Oct. 31, 1997

Physician | Telephone No. | Medical Record

Alt. Physician | Alt. Telephone

Allergies NKA | Rehabilitative Potential

Diagnosis

Patient Number | Medicare Number | Complete Entries Checked: By: J. Smithyn Title | Date:

Pugh, Cedric 182373 | PATIENT CODE | ROOM NO.

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Motrin 600mg bid x 5 days 8/27 - 9/1	09	A	X																										
	18	A	X																										
Robaxin 1000mg bid x 7 days 8/27 - 9/3	09	A	A	A	X																								
	18	A	(A)	A	X																								
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 8/27 THROUGH 9/3/97

Physician | Telephone No | Medical Record

Alt. Physician | Alt. Telephone

Allergies | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked: By: Title: Date:

PATIENT Pugh, Cedric | PATIENT CODE K2373 | ROOM NO | BED | FAC

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Motrin 600mg BID x 5 days 8/27/97 9/1/97	0900	→																											
	1800	→																											
Robaxin 1000mg BID x 7 days 8/27/97 9/3/97	0900	→																											
	1800	→																											
MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	2

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 8/1/97 THROUGH 8/31/97

Physician Dr. Mauney

Alt. Physician

Telephone No

Alt. Telephone

Medical Record

Allergies

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By: A. Parks Title: LPN Date: 8/2

PATIENT Pugh Cedric

PATIENT CODE 102333

ROOM NO

BED

FACI

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Pugh, Cedric	**Inmate Number:**	182373PU
Service Authorized:	Office Visits: Op Orthopedics Referral	**Effective Dates:**	04/03/2006
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	16049862	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report
***** For security and safety, please do not inform patient of possible follow-up appointments. *****
Signature of Consulting Physician: Date Time
Reviewed and Signed By Medical Director: Date Time

Please send this f... Form must be Complete and Legible. You must Type ... the Authorization Letter to the service provider ... me of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843

Site Phone #: (334) 567-1548

Site Fax #: (334) 567-1538

Will there be a charge? ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Patient Name: (Last, First,) Pugh, Cedric

Alias: (Last, First,) 182373

Inmate # 182373

SS Number [redacted]

Date: (mm/dd/yy) 03/15/06

Date of Birth: (mm/dd/yy) [redacted]

PHS Custody Date: (mm/dd/yy) 08/06/97

Potential Release Date: (mm/dd/yy) 08/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. Buskirk

Facility Medical Director Signature and Date: 3/15/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: 1 ☐ Other:

Specialist referred to: Dr. Chung

Type of Consultation, Treatment, Procedure or Surgery: FOV r finger 6/1/06 @ 2:15

Diagnosis: R middle finger laceration + tissue loss

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☑ Pertinent Documents have been attached and faxed.

Take X-rays

History of illness/injury/sypmtoms with Date of Onset:

FOV for laceration of 3rd digit R hand S/P debridement

Results of a complaint directed physical examination:

R middle finger laceration + tissue loss - wound healing well - sutures out

Previous treatment and response (including medications):

FOV S/P debridement of R middle finger

Need appointment on 6/1/06

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class:

CPT code:

UR Auth # 1604086

Please send this form ... must be Complete and Legible. You must Type or P... Authorization Letter to the service provider at ... of the Appointment

PHS 2

DEMOGRAPHICS

Site Name & Number: 843 - STATON

Site Phone #: 334-567-1548

Site Fax #: 334-567-7167

Will there be a charge? ☑ Yes ☐ No

Sex: ☑ Male ☐ Female

Patient Name: (Last, First) Pugh, Cedric

Alias: (Last, First)

Inmate # 182373

SS Number [redacted]

Date: (mm/dd/yy) 3/02/06

Date of Birth: (mm/dd/yy) [redacted]

PHS Custody Date: (mm/dd/yy) 08/06/97

Potential Release Date: (mm/dd/yy) 08/ /01

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date: J. M. Peasant Sr 3/2/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA) ☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 3/13/06

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: 1 ☐ Other:

Specialist referred to: Dr Chung Orthopedist

Type of Consultation, Treatment, Procedure or Surgery: FOV (R) middle finger debridment

Diagnosis: (R) middle finger fx fissure loss

ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☑ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset: S/P middle finger debridment today

Results of a complaint directed physical examination: finger c pressure dressing

Previous treatment and response (including medications): FOV needed in 2WK (approx. 3/16/06))

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: / /

Regional Medical Director Signature, printed name and date required: / / (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class: CPT code: UR Auth #:

05a - UM Referral review form

FAXED 3/10/06 AN

A. Thompkins 3/10/06

And copy of Dr Chung's note of 3/2/06

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Pugh, Cedric	**Inmate Number:**	182373PU
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	03/13/2006
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Staton Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	16049964	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: _____ Date _____ Time

Reviewed and Signed By
Medical Director: _____ Date _____ Time

Form must be Complete and Legible. You must Type or Print
Please send this form ... Authorization Letter to the service provider at t... of the Appointment

PHS 2

DEMOGRAPHICS

Site Name & Number: 843 - STATON

Patient Name: (Last, First) Pugh, Cedric

Date: (mm/dd/yy) 3/02/06

Site Phone #: 334-567-1548

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax #: 334-567-7167

Inmate #: 182373

PHS Custody Date: (mm/dd/yy) 08/06/97

Will there be a charge? ☑ Yes ☐ No

Sex: ☑ Male ☐ Female

SS Number: [redacted]

Potential Release Date: (mm/dd/yy) 08/ /01

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

RECEIVED APR 20 2006

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date: J M Peasant for 3/2/06

☐ Service meets criteria for approval via protocol

History of Illness/Injury/symptoms with Date of Onset: s/p middle finger debridement today

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)
☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 3/13/06
(This starts the approval window for the "open authorization period")

Results of a complaint directed physical examination: finger c̄ pressure dressing

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other
Number of Visits/Treatments: 1

Specialist referred to: Dr Chung orthopedist

Previous treatment and response (including medications): F/U needed in 2 wk (approx. 3/16/06)

Type of Consultation, Treatment, Procedure or Surgery: F/U (R) middle finger debridement

Diagnosis: (R) middle finger tip of tissue loss
ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.
☑ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:
☐ Alternative Treatment Plan (explain here):
☑ Offsite Service Recommended and Authorized
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information.
Date resubmitted: / /

Regional Medical Director Signature, printed name and date required: [signature] 030206 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: OK	Med Class: OV	CPT code: 99024	UR Auth #: 11049964

Written in left margin: For copy of Dr Chung's orders of 3/2/06

05a - UM Referral Review Form

FAXED 3/10/06 AN

A. Humphrey 3/10/06

Form must be Complete and Legible. You must Type o

Please send this fo ... the Authorization Letter to the service provider at ... ne of the Appointment

PHS

2

DEMOGRAPHICS

Site Name & Number: Staton 843 ECC	Patient Name: (Last, First,) Pugh, Cedric	Date: (mm/dd/yy) 03/15/06
Site Phone # (334) 567-1548	Alias: (Last, First,) 182373	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # (334) 567-1538	Inmate # 182373	PHS Custody Date: (mm/dd/yy) 08/06/97
Will there be a charge? ☐ Yes ☐ No — Sex ☐ Male ☐ Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 08/ /07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):________

CLINICAL DATA

Requesting Provider: ☑ ~~Physician~~ ☐ NP, PA ☐ Dental

J Peasanton

Facility Medical Director Signature and Date: J. Peasanton 3/15/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ ~~Office Visit (OV)~~ ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other:____

Number of Visits/Treatments: 1

Specialist referred to: Dr. Chung

Type of Consultation, Treatment, Procedure or Surgery: F/U r finger

Diagnosis: R middle finger Laceration + tissue Loss

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☑ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:

F/U for laceration of 3rd digit R hand s/p debridement

Results of a complaint directed physical examination:

R middle finger laceration c tissue loss - wound healing well - sutures out

Previous treatment and response (including medications):

F/U s/p debridement of R middle finger

Need Appointment on 4/3/06

For security and safety, please do not inform patient of possible follow-up appointments

For last office visit dated 3/13/06

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

Form must be Complete and Legible. You must Type or Print

Please send this form ... Authorization Letter to the service provider at t... of the Appointment

PHS 2

DEMOGRAPHICS

Site Name & Number: 843 - STATON	Patient Name: (Last, First,) Pugh, Cedric	Date: (mm/dd/yy) 3/02/06
Site Phone # 334-567-1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # 334-567-7167	Inmate # 182373	PHS Custody Date: (mm/dd/yy) 08/06/97
Will there be a charge? ☑ Yes ☐ No / Sex ☑ Male ☐ Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 08/ /07

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date:

J. M. Peasant for 3/2/06

☐ Service meets criteria for "approval via protocol"

History of illness/injury/sypmtoms with Date of Onset:

S/P middle finger debridement today

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA) ☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 3/13/06

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: 1 ☐ Other:

Results of a complaint directed physical examination:

finger c pressure dressing

Specialist referred to: Dr Churng orthopedist

Type of Consultation, Treatment, Procedure or Surgery:

FOV (R) middle finger debridement

Diagnosis: (R) middle finger for fracture loss

ICD-9 code:

Previous treatment and response (including medications):

FOV needed in 2 WK approx. 3/16/06))

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☑ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: / /

Regional Medical Director Signature, printed name and date required:

/ / (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

For copy of Dr Churng's order of 3/2/06

05a - UM Referral review form

FAXED 3/10/06

A. Thompson Meyer 3/10/06

Pugh, Cedric AIS 182373

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report
[illegible handwriting]
[illegible handwriting]
[illegible handwriting]
[illegible handwriting]
***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: [signature] Date ______ Time ______

Reviewed and Signed By Medical Director: [signature] 3/13/06 Date ______ Time ______

05/20/2004

E0606100177 PUGH,CEDRIC
DOB: 09/21/75 Age:30Y MR #:279152
Admit Date/Time: 03/02/06 0854A
2015 CHUNG,TAI Q
Patient Information

Baptist HEALTH

PHYSICIAN'S ORDERS

Height:_____ Weight:_____
Drug Sensitivities and Allergies ☐ NKDA ☐ Yes, list: _____

New Admissions Only:
1. Diagnosis:
2. Admit Status: ☐ Inpatient Admission ☐ Outpatient Status ☐ Observation Status

Date	Time	
		DC
3/2/06		Give my orders to the attendants to return to the facility
		Keep @ heel elevated
		Change dressing pm -
		Cephalexin 500 mg po qid x 2 days
		Vicodin 5 po q6h prn pain
		See me in 2wks
		Chung
		Physician Signature:

The following abbreviations are not to be written or used!

Q.O.D., QOD, q.o.d, qod	Trailing zero (X.0 mg)	Lack of leading zero (.X mg)	MS	MSO4	MgSO4	U	q.d., QD, qd	IU

PH 350

Form #PH 35001 Revised 11/18/05

E0606100177 PUGH,CEDRIC
DOB: 09/21/75 Age:30Y MR #:279152
Admit Date/Time: 03/02/06 0854A
2015 CHUNG,TAI Q
Patient Information

Baptist Health

OUTPATIENT SURGERY POSTOP INSTRUCTIONS

You are urged to follow the specified instructions carefully. In order to continue your care at home, please follow the instructions checked below.

1. **GENERAL ANESTHESIA, LOCAL ANESTHESIA WITH SEDATION OR REGIONAL ANESTHESIA**
   - ☑ Do not drive, operate machinery, power tools or cook a meal for 24 hours.
   - ☑ Do not consume alcohol, tranquilizers, sleeping medications or any non-prescribed medication for 24 hours.
   - ☑ Do not make important decisions or sign any important papers in the next 24 hours.
   - ☑ You should have someone with you tonight at home.
   - ☐ Children may appear flushed for several hours after surgery. Do not ride a bicycle, skateboard, or play on gym sets for 24 hours.
   - ☐ The blocked extremity may be numb for several hours. Keep in a sling until all function returns.
   - ☐ You may experience a slight sore throat. You may gargle with salt water or use a throat lozenge.
2. **ACTIVITY**
   - ☑ You are advised to go directly home. Restrict your activities today. Resume light to normal activity tomorrow.
   - ☐ You may resume normal activity today.
   - ☐ Specific activity instructions:________
   - ☐ Go to physical therapy.
   - ☐ Do not engage in strenuous activity that may place stress on your incision.
3. **FLUIDS AND DIET**
   - ☑ Begin with clear liquids, boullion, dry toast or soda crackers.
   - ☑ If not nauseated, you may go to a regular diet when you desire. Greasy and spicy foods are not advised.
   - ☐ Special diet________
   - ☐ If nauseated, refrain from heavy foods. Try dry crackers, clear liquids and jello. If nausea persists, notify your doctor.
4. **MEDICATIONS**
   - ☑ Prescription sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications. Prescriptions: V [illegible]
   - ☐ You may take a non-prescription "headache remedy" medication that you normally use with surgeon's approval. Preferably not containing aspirin.
   - ☐ You may resume your daily prescription medication schedule.
   - ☐ You may receive a pain injection during your stay with us. Be aware that the injection may leave a small bruise and the site may be sore to the touch for several days.
5. **OPERATIVE SITE**
   - ☑ Keep dressing clean and dry.
   - ☐ Do not change dressing unless instructed by physician.
   - ☐ Change dressing when soiled or wet.
   - ☐ May remove dressing:________
6. **EXTREMITIES, ARMS, HANDS, LEGS, FEET**
   - ☑ Keep operative extremity elevated as much as possible to lessen swelling and discomfort. *
   - ☑ Apply ice as directed.
   - ☑ Observe the affected extremity for circulation or nerve impairment, coldness, change in color, numbness or tingling.
7. **GYNECOLOGICAL PROCEDURES**
   - ☐ D & C and Laparoscopic patients may have varying amounts of vaginal discharge for a few days.
   - ☐ Laparoscopic patients may develop shoulder pain in first 24 hours from residual gas.
8. **EAR, NOSE OR THROAT**
   - ☐ No water or foreign objects in ear.
   - ☐ Voice rest for:________
   - ☐ May change the nasal tip dressing as needed and as demonstrated.
   - ☐ Keep head of bed elevated.
9. **FOLLOW UP CARE**
   - ☐ Your return office appointment is: per Dr. Chung
   - ☐ Return to work as instructed by physician.

Call your surgeon if you have any problems that concern you. After office hours, you can reach your physician through his/her answering service. If you need immediate attention, go to the emergency room nearest you.

SPECIFIC COMPLICATIONS TO WATCH FOR

- Fever over 101° F by mouth
- Pain not relieved by medication ordered
- Swelling around operative area
- Increased redness, warmth, hardness of area
- Difficulty breathing
- Persistent nausea and vomiting
- Numbness, tingling, discoloration or cold fingers/toes
- Blood-soaked dressing (small amounts of oozing is normal)
- Increasing drainage from surgical area of exam site.
- Inability to urinate

OTHER INSTRUCTIONS: Follow Dr. Chung's discharge orders.

Your Name: Frederick Barton Relation to patient: Officer Phone:________

Date: 3/2/06 Time: 1400 Signature: [illegible] NURSE

WHITE- Medical Record YELLOW- Patient

DI 1440

FORM # DI 14408 REV 6/30/04
(Replaces HE-051)

<< Back Print

STATE OF ALABAMA
INMATE HEALTHCARE AUTHORIZATION

Enrollment
Telephone (334) 833-5948
Toll Free (866) 853-1384
Fax (334) 240-1488

Blue Cross Blue Shield of Alabama
(877) 231-7239

Prison Health Services
Telephone (334) 395-5973
Toll Free (877) 279-1335
Fax (334) 395-8156

3/2/2006

Inmate Name	**PUGH , CEDRIC ROMAN**	**Inmate #**	**00182373**
Facility Name	**ELMORE CORRECTIONAL FACILITY**		
Facility Address1	**POB 8**		
Facility Address2			
City	**ELMORE**		
State	**AL**		
Zipcode	**36022**		

*** Attention Health Care Provider ***

For Hospital/Facility Claims:
All facility claims for inpatient and outpatient services should be submitted directly to Blue Cross and Blue Shield of Alabama. Please submit your facility charges to Blue Cross under group **57688** with contract number **XAJ624645779** as you currently do for all other Blue Cross subscribers. This process applies to facility charges only and does not include physician services.

Utilization Management Review:
All concurrent in-patient reviews must be provided to PHS Regional Office in Montgomery. The contact person is Michelle Pope, Utilization Management Coordinator. (334) 395-5973 Ext 14

For charges not covered under SEIB - BC/BS Program:
For Payment, Please Submit Claims with Inmate number to:
Prison Health Services
P.O.Box 967
Brentwood TN 37024-0967

- Medicare/Medicaid does not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number).
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
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- Payment will not be processed until a clinical summary is received.

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS (1)

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First,) Pugh, Cedric	Date: (mm/dd/yy) 02 28 06
Site Phone # (334) 567-1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # (334) 567-1538	Inmate # 182372	PHS Custody Date: (mm/dd/yy) 08, 06, 97
Will there be a charge? ☐ Yes ☐ No — Sex ☐ Male ☐ Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 08, __, 07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):_____

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

J. Peasant...

Facility Medical Director Signature and Date:

J. Peasant... 2/28/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☑ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other:_____

Number of Visits/Treatments: _____

Specialist referred to: Baptist South @ Dr Chung

Type of Consultation, Treatment, Procedure or Surgery: surgical debridement of (R) index finger & laceration

Diagnosis: Avulsion & Fx of (R) index finger

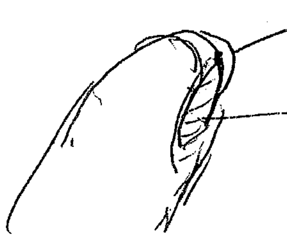
ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☒ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset: 30 yo BO caught finger in mixer. Loosing approx 1/3 of outer aspect of (R) middle finger. Pt seen by Ortho & needs graft & debridement

Results of a complaint directed physical examination:



Previous treatment and response (including medications): ER / Ortho visit. Pt need debridement + possible graft

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required: ___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

05a - UM Referral review form

* Send copy of Dr Chung's Note + Orders of 2/28/06

Urgent

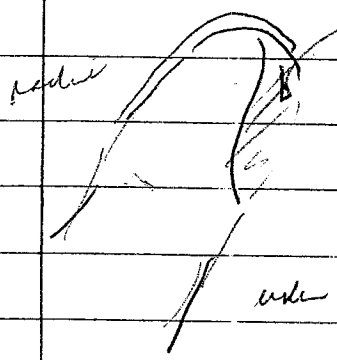
O. Humphrey

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:

2/27/06



2/27/06

TAI Q. CHUNG M.D.

DATE 2/17/06

NAME Cedric Pugh

PHONE ____ HOME _____ WORK _____

PROCEDURE Debridement & repair @ middle finger
skin graft from groin

DX Partial amputation CPT _____

WHERE _____ OUTPATIENT

TIME NEEDED 1 hr

ANETHESIA GENERAL ____ BLOCK ____ LOCAL ____ CHOICE

SPEICAL EQUIPMENT _____

ASSISTANT _____

LABS _____

BLOOD TRANSFUSIONS _____

OTHER INSTRUCTIONS _____

SURGERY OR TEST DATE _____

INSURANCE INFORMATION _____

Cedric Pugh

Patient Information

Baptist Health

PHYSICIAN'S ORDERS

Height:_____ Weight:_____

Drug Sensitivities and Allergies ❑ NKDA ❑ Yes, list: _____

DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE
'u' or 'U'	Unit	MS, MSO4 MgSO4	Spell out words	TIW	Spell out words	Per os or OS	Spell out by mouth/oral
IU	International Unit	.Xmg	0.Xmg	µg	microgram	BT	Spell out Bedtime
QD/QOD	Spell out words	X.0 mg	'X' mg	AD, AS, AU	Spell out words	QN or qn	Spell Out Nightly or at Bedtime

Date	Time	ROUTINE PRE OPERATIVE ORDERS
		DR. Tim Chung
2/2/06		1. Operative permit for Debridement + repair (R) medial finger, possible skin graft from groin
		2. LAB: check appropriate diagnosis

A. ✓ **CBC:**

_____ Pre op patient [V72 83]
_____ Long term use of medications
_____ Fever
_____ Abdominal pain
_____ Other

B. _____ **TYPE & SCREEN**

C. _____ **CHEM 7:**

_____ Edema
_____ Hypertensive disease
_____ Long term use of medications
_____ Diabetic
_____ Nephropathology
_____ Dizziness
_____ Other

D. _____ **PT PTT**

_____ Known or suspected coagulation abnormality
_____ Anticoagulatn therapy
_____ Hemorrhage or anemia
_____ Pulmonary congestion
_____ Other
_____ Cirrhosis hepatitis
_____ CHF
_____ Cardiac dysrhythmia
_____ Dysfunctional uterine bleeding
_____ Menorrhagia

E. _____ **DRUG LEVELS: circle appropriate drug**

_____ Patients taking Digoxin Tegretol Theophylline Dilantin Depakote Phenobarb
_____ Other

F. _____ **URINE PREGNANCY**

_____ On all menstruating females

page 2 continued on back

PH 350

DO NOT WRITE BELOW THIS LINE

Pugh

Date	Time	ROUTINE PRE OPERATIVE ORDERS DR. _____
		G. _____ UA: _____ Diabetic _____ Fever _____ Renal glycosuria _____ Dysuria _____ Dehydration _____ Abdominal & pelvic pain _____ Stress incontinence _____ Long term use medication **H. ADDITIONAL LAB TESTS:** _____ _____ _____ _____ **3. EKG:** _____ MVP/murmer or other valve disorder _____ Tachycardia/palpitation _____ Chest pain discomfort pressure _____ Ischemic heart disease (hx MI) _____ Hypertensive disease _____ Dizziness _____ Pulmonary congestion & hypostasis (CHF) _____ Other _____ Electrolyte/fluid abnormality
		4. CHEST XRAY: _____ Existing pulmonary disease (asthma COPD etc) Specify _____ _____ Existing cardiac disease (hypertension CHF etc) _____ Internal Injury _____ Fever _____ Cough _____ Disorders of bone & cartilage (arthritis) _____ Other
		5. _____ Antibiotic: _____
		6. _____ NPO after midnight
		7. _____ ❑ TED or ❑ SCD hose prior to surgery
		8. _____ **Other Orders** _____ _____ _____
		9. Anesthesia Consult ❑ Yes ❑ No
		Page 2 of 2
		Physician Signature:

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: 843 - STATON	Patient Name: (Last, First,) Pugh, Cedric	Date: (mm/dd/yy) 02/24/06
Site Phone # 334-567-1548	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # 334-567-7167	Inmate # 182373 ECC	PHS Custody Date: (mm/dd/yy) 8/ 6/ 97
Will there be a charge? ☑ Yes ☐ No / Sex ☑ Male ☐ Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 8/ /2007

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☑ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D. / L Peasantmd

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy): / /

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: 1 ☐ Other:

Specialist referred to: Dr Chang

Type of Consultation, Treatment, Procedure or Surgery:
Evaluate i tx

Diagnosis: Partial Traumatic Amputation (R) 3rd digit
ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset:
2/23/06 → Lt finger caught in mixer c ≅ ¼ of finger amputated (R) 3rd digit. Sent to BMCS for tx; needs to see ortho for tx

Results of a complaint directed physical examination:
(R) 3rd finger wrapped c pressure dsg. DSO not removed @ this time prior to ER visit ¼ of finger c traumatic amputation

FAXED 2/24/06

Previous treatment and response (including medications):
Appt scheduled c Dr Chang on 2/27/06 @ 1415 ① URGENT
TAKE XRAYS to Appt

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized
☐ Alternative Treatment Plan (explain here):
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information.

Date resubmitted: / /

Regional Medical Director Signature, printed name and date required:

/ / (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

E. Ellis, RN

t Health
gency Room Prescription Form

☐ SOUTH 286-2843
☐ EAST 244-8448
☐ PRATTVILLE 361-4239

PRESCRIPTION FORM

PUGH,CEDRIC
BC 05400391
DOB: [redacted] Age:30Y MR #:598203
Admit Date/Time: 02/23/06 1132A
91 RIOS,JULIO E

Location South

Weight | Phone | Allergies

MEDICINES PRESCRIBED | If non, check this box: ☐ | VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND.

	Name/Strength	Number	Schedule / Duration	No Refills	Refills
1.	Lortab 7.5	#12	1 PO Q4H prn pain	☐	
2.	Keflex 500mg	#40	1 PO TID	☐	
3.				☐	
4.				☐	
5.				☐	

Emilio Belaval
AL 22654
DEA - BB5295248

David G. Alexander
DO - 657
AA3259226

Victoria L. Beckman
DEA - BB62553885
AL - 22440

Joel Sullivan
DEA - AS2020066
ARN - 10094

John Moorehouse
DEA - AM6869119
ARN - 7151

Steven G. O'Mara
DEA - BO1736074
DO - 713

Ronald A. Shaw
AL - 6388
DEA - AS5646813

Jessie Austin
DEA - AA8394075
ARN - 8595

Brad Frisbie
DEA - BF2524583
ARN - 15396

Julio Enrico Rios
ARN - 21678
DEA - BR2471326

Tom Decaro
DEA - AD2628355
ARN - 11369

Thomas Arnold
DEA - AA9548655
ARN - 16275

Wallace Falero
AL - 9405
DEA - AF1692119

Henry Kurusz III
DEA - AK2572116
AL - 22198

Paul Tanaka
ARN - 7153
DEA - 8922-898

James M. Bradwell
DEA - BB6422086
AL - 22767

Label all prescriptions
No refills

Product Selection Permitted

M.D./D.O.

Dispense as Written

M.D./D.O.

BSB-0082 (06/02)

BAPTIST MEDICAL CENTER
Nursing Service Department
Emergency Room

INSTRUCTIONS FOR THE CARE OF LACERATIONS

Keep wound elevated above the level of the heart.

Keep dressing clean and dry.

If possible, clean 1 times a day with soap and water; keep covered with layer of Neosporin ointment at all times.

: swelling, redness, pain and some drainage is expected after any ıd is stitched. Any increase in any of these suggests the possibility infection.

Observe for sign of infection.

Your wound was cleaned in the Emergency Department but infection is still possible. Signs of infection are:

a. Swelling.
b. Excessive redness.
c. Increasing pain or tenderness.
d. Heat - either locally or elevated temperature.
e. Excessive drainage from the wound.

CD4507
REVISED 4-2004

BC605400391 PUGH,CEDRIC
DOB: [redacted] Age:30Y MR #:598203
Admit Date/Time: 02/23/06 1132A
919 RIOS,JULIO E

t Health
'gency Room
Discharge Instructions

DISCHARGE INSTRUCTIONS - MEDICAL CHART

Weight	Phone	Allergies	Location South

MEDICINES PRESCRIBED If non, check this box: ☐ **VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND.**

	Name/Strength	Number	Schedule / Duration	No Refills	Refills
1.	Keflex 500	#14	1 po qid x 7 days	☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	

INSTRUCTION SHEET(S) GIVEN

- ☐ Asthma
- ☐ Back Pain
- ☐ Cast / Splint Care
- ☐ Crutches
- ☐ Fever
- ☐ Fracture
- ☐ Head Injury
- ☐ Otitis Media
- ☐ Sprains / Bruises
- ☐ STD
- ☐ Threatened Ab
- ☐ Vomiting / Diarrhea
- ☑ Wound Care
- ☐ Other(s)_____

Return for signs of infection
> Redness
> Swelling
> Drainage
> Heat

Additional Instructions:

① Neosporin ointment
② Keep Wound Clean & dry
③ F/U 3 d - 5 d

Return 3-5 days for checkup

Referred to:
☑ Dr. Curtis 613-9000
Phone: _____
☑ Call on next business day for follow-up appointment
in _____ days / weeks ☐ next available

☐ Return to Emergency Dept. in _____ hours / days for recheck
☑ If no improvement or your condition worsens, call your private physician or return to the Emergency Department for a recheck.
☐ Learning needs assessed ☐ Instructions Modified: _____
☐ Education provided on new medication _____

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

☒ Patient
☐ Relative
☐ Other_____

X Cedric Pugh

Time Released > 1458 Hrs.

Instructed By: M. Dungy RN HPS

Physician: [illegible]

WORK/ SCHOOL STATEMENT from the Emergency Department

Patient Name

Date

- ☐ Patient was seen by Dr.
- ☐ No athletics / physical education: _____ days*
- ☐ May return to work / school without restrictions
- ☐ Will require time off work / school. Estimated time: _____ days*
- ☐ Must be reevaluated by family / occupational physician before returning to school / work.
- ☐ May return to restricted duties for_____ days*
  Restrictions: _____
- ☐ ---------- was here with relative/ child.
- ☐ Other: _____

Time off from School or Work longer than 3 days should be approved by a Personal or Company/ Occupational Medicine Physician, unless otherwise stated

BSB-0082 (06/02

EYE EXAMINATION SHEET

TO: (Service Physician) Dr. Bradford

FROM: (Requesting Ward, Med. Fac. Phys.) Elmore Care Center

Date of Request: 12/23/05

Reason For Request: (Complaints and Finding)

Eyes DC @ 1018AM

Past History

Ø C/o

Old Rx

Signature

Type of Consult ☐ Emergency ☐ Routine

CONSULTATION REPORT

Subjective: OD 20/20 OS 20/20 OU 20/20

OPHTH: 206 c/o / WMn

New Rx: OD OS

Seg. Ht.

Ext:
Date Dispensed & Initials:

Seg. Type:

IDP & Time:

PW/PR NOT Rx'd

Frame:
Size:
Color:

12/23/05

OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	I D No.
Rush, Cedric			30	B/M	182373

F-65 Rev. (1-95)

LabCorp Laboratory Corporation of America
LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000
Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
138-205-5208-0	S	MB	COMPLETE	Page #: 1

ADDITIONAL INFORMATION

ECC FASTING: Y
DOB: [redacted]

PATIENT NAME	SEX	AGE(YR./MOS.)
PUGH,CEDRIC	M	30 / 7

PT. ADD.:

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/17/2006	13:27	5/18/2006	5/19/2006	7:46	5053

CLINICAL INFORMATION
CD-41147610579

PHYSICIAN ID.	PATIENT ID.
PEASANT J	182373

ACCOUNT: Staton Correctional Facility
Prison Health Services
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

	TEST	RESULT		LIMITS	LAB
	CMP12+LP+TP+TSH+6AC+CBC/D/Plt				
	Chemistries				MB
	Glucose, Serum	87	mg/dL	65 - 99	MB
	Uric Acid, Serum	6.4	mg/dL	2.4 - 8.2	MB
	BUN	10	mg/dL	5 - 26	MB
	Creatinine, Serum	1.1	mg/dL	0.5 - 1.5	MB
	BUN/Creatinine Ratio	9		8 - 27	
	Sodium, Serum	142	mmol/L	135 - 148	MB
	Potassium, Serum	4.7	mmol/L	3.5 - 5.5	MB
	Chloride, Serum	105	mmol/L	96 - 109	MB
	Calcium, Serum	9.6	mg/dL	8.5 - 10.6	MB
	Phosphorus, Serum	3.8	mg/dL	2.5 - 4.5	MB
	Protein, Total, Serum	7.8	g/dL	6.0 - 8.5	MB
	Albumin, Serum	4.9	g/dL	3.5 - 5.5	MB
	Globulin, Total	2.9	g/dL	1.5 - 4.5	
	A/G Ratio	1.7		1.1 - 2.5	
	Bilirubin, Total	0.5	mg/dL	0.1 - 1.2	MB
	Alkaline Phosphatase, Serum	81	IU/L	25 - 150	MB
	LDH	139	IU/L	100 - 250	MB
	AST (SGOT)	23	IU/L	0 - 40	MB
	ALT (SGPT)	32	IU/L	0 - 55	MB
	GGT	24	IU/L	0 - 65	MB
	Iron, Serum	97	ug/dL	40 - 155	MB
					MB
	Lipids				MB
	Cholesterol, Total	185	mg/dL	100 - 199	MB
	Triglycerides	43	mg/dL	0 - 149	MB
	HDL Cholesterol	52	mg/dL	40 - 59	MB
	VLDL Cholesterol Cal	9	mg/dL	5 - 40	
>	LDL Cholesterol Calc	124 H	mg/dL	0 - 99	
	Comment				MB
	If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.				
	T. Chol/HDL Ratio	3.6	ratio units	0.0 - 5.0	
	Estimated CHD Risk	0.5	times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

	Men	Women
1/2 Avg.Risk	3.4	3.3
Avg.Risk	5.0	4.4
2X Avg.Risk	9.6	7.1

Continued on Next Page

LabCorp Laboratory Corporation of America
LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000
Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
138-205-5208-0	S	MB	COMPLETE	Page #: 2

ADDITIONAL INFORMATION

ECC FASTING: Y
DOB [redacted]

PATIENT NAME	SEX	AGE(YR./MOS.)
PUGH,CEDRIC	M	30 / 7

PT. ADD.:

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/17/2006	13:27	5/18/2006	5/19/2006	7:46	5053

CLINICAL INFORMATION
CD- 41147610579

PHYSICIAN ID.	PATIENT ID.
PEASANT J	182373

ACCOUNT: Staton Correctional Facility
Prison Health Services
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

	TEST	RESULT		LIMITS	LAB
	3X Avg.Risk	23.4		11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

	Thyroid				MB
	TSH	0.668	uIU/mL	0.350 - 5.500	MB
	Thyroxine (T4)	8.8	ug/dL	4.5 - 12.0	MB
	T3 Uptake	31	%	24 - 39	MB
	Free Thyroxine Index	2.7		1.2 - 4.9	
	CBC, Platelet Ct, and Diff				MB
>	White Blood Cell(WBC)Count	3.9L	x10E3/uL	4.0 - 10.5	MB
	Red Blood Cell (RBC) Count	5.28	x10E6/uL	4.10 - 5.60	MB
	Hemoglobin	15.4	g/dL	12.5 - 17.0	MB
	Hematocrit	46.1	%	36.0 - 50.0	MB
	MCV	87	fL	80 - 98	MB
	MCH	29.1	pg	27.0 - 34.0	MB
	MCHC	33.4	g/dL	32.0 - 36.0	MB
	RDW	13.2	%	11.7 - 15.0	MB
	Platelets	226	x10E3/uL	140 - 415	MB
>	Neutrophils	28 L	%	40 - 74	MB
>	Lymphs	59 H	%	14 - 46	MB
	Monocytes	12	%	4 - 13	MB
	Eos	1	%	0 - 7	MB
	Basos	0	%	0 - 3	MB
>	Neutrophils (Absolute)	1.1L	x10E3/uL	1.8 - 7.8	MB
	Lymphs (Absolute)	2.3	x10E3/uL	0.7 - 4.5	MB
	Monocytes(Absolute)	0.5	x10E3/uL	0.1 - 1.0	MB
	Eos (Absolute)	0.0	x10E3/uL	0.0 - 0.4	MB
	Baso (Absolute)	0.0	x10E3/uL	0.0 - 0.2	MB

LAB: MB LabCorp Birmingham DIRECTOR: John Elgin N MD
1801 First Avenue South, Birmingham, AL 35233-0000

LabCorp [redacted]

Specimen #	Type	Primary	Report Status	
[illegible]				

Additional Information

Patient Name	Sex	Age (Yr/Mos)
[illegible]		

Patient Address

Date Collected	Date Entered	Date Reported	
[illegible]	[illegible]	[illegible]	

Clinical Information

Physician ID	Patient ID
[illegible]	[illegible]

Account

[illegible]

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Urobilinogen,Semi-Qn	[illegible]		mg/dL	0.0 - 1.0	[illegible]
Nitrite, Urine	Negative			Negative	[illegible]
Microscopic Examination					
Microscopic follows if indicated.					[illegible]
Microalbumin, Random Urine					
Microalbum.,U,Random	[illegible]		ug/mL	0.0 - 17.0	[illegible]

[illegible] LabCorp Birmingham Director: John Elgin, MD
1801 First Avenue South, Birmingham, AL 35233
For inquiries, the physician may contact: Branch: [illegible] Lab: [illegible]

LAST PAGE OF REPORT

FINAL

REPORT

ELMORE COMMUNITY HOSPITAL LABORATORY

500 HOSPITAL DRIVE
WETUMPKA, AL 36092
PH: (334)567-4311 FAX (334)514-0723

THANK YOU FOR SELECTING OUR FACILITY!

Name: PUGH, CEDRIC
Patient Number: 054655
Birth: [redacted] Age: 30 years Sex: M
DOCTOR: STATION CORR FACILITY
Home Phone: (000)000-0000
HOSPITAL NO 378498
DR NAME PEASANT

Accession: 156172 STAT
Fasting: UNKNOWN
Collected/Drawn: 3/12/2006 09:28 PM
Received in Lab: 3/12/2006 09:28 PM

Test Name	Result	Units	Flag	Reference Range
GENTAMYCIN, TROUGH				*Run By: NJC on 3/12/2006 11:09:29 PM*
GENTAMYCIN TR	0.4	MCG/ML		0.0 - 2.0

Test performed at Community Hospital in Tallassee, Alabama

--- End Of Report ---

Reviewed By: _____ Date: _____

3-15-06

ELMORE COMMUNITY HOSPITAL LABORATORY

500 HOSPITAL DRIVE
WETUMPKA, AL 36092
PH: (334)567-4311 FAX (334)514-0723

THANK YOU FOR SELECTING OUR FACILITY!

Name:	PUGH, CEDRIC			Accession: 156171	STAT
Patient Number:	054655			Fasting: UNKNOWN	
Birth:	[redacted]	Age: 30 years	Sex: M	Collected/Drawn: 3/12/2006 09:27 PM	CBN
DOCTOR:	STATON CORR FACILITY			Received in Lab: 3/12/2006 09:27 PM	NJC
Home Phone:	(000)000-0000				
HOSPITAL NO.	328498				
DR NAME	PEASANT				

Test Name	Result	Units	Flag	Reference Range
GENTAMYCIN, PEAK				*Run By: NJC on 3/13/2006 at 09:29 PM*
GENTAMYCIN PEAK	0.5	MCG/ML	LOW	5.0 - 12.0

Test performed at Community Hospital in Tallasee, Alabama

--- End Of Report ---

Reviewed By: _____ Date: _____

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME: Pugh Cedric

PRISON ID: 182313

DATE SUBMITTED: 5/7/07

Hmm w/ H P 69

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY		NEGATIVE (NEG)	
RPR	✓ NR	NON-REACTIVE (NR)	
URINALYSIS			
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

"A" These results are unreliable due to the age of the specimen.
"H" These results are unreliable due to the hemolyzed condition of the specimen.
"A+H" These results are unreliable due to the age and hemolyzed condition of the specimen.

CLIA ID NO. 01D0706289

WAYNE D. MERCER, PHD
LABORATORY DIRECTOR

TEST	RESULT	OUT OF RANGE	UNITS	LIMITS	LMS

VENTRESS
U/A DIPSTICK REPORT

NAME Pugh, Cedric AIS# 182373

DOB [redacted] R/S BM

DATE 7/30/98 TIME 0842

APPERANCE: COLOR yellow CLARITY clear

BLOOD: neg

BILLIRUBIN: neg

URUBILLNOGEN: 4

KETONES: neg

PROTEIN: neg

NITRATE: neg

GLUCOSE: neg

PH 8

SPECIFIC GRAVITY 1.010

LEUCOCYTES neg HEMOGLOBIN neg

✓ WNL ✓ ABNORMAL

OBTAINING NURSE'S SIGNATURE L Neal RN

MD SIGNATURE

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME
Pugh Cedric

PRISON ID
182373

DATE SUBMITTED
8-20-97

np 118

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY ✓	NR	NEGATIVE (NEG)	
RPR ✓	NR	NON-REACTIVE (NR)	
URINALYSIS ✓	NEG		
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

LabCorp Laboratory Corporation of America
LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000 Phone: 334-263-5745

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
343-684-3278-0	S	YX	COMPLETE	Page #: 1

ADDITIONAL INFORMATION

ECC FASTING: Y
DOB: [redacted]

PATIENT NAME	SEX	AGE(YR./MOS.)
PUGH,CEDRIC	M	30 / 2

PT. ADD.:

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
12/08/2005	12:20	12/09/2005	12/10/2005	8:27	2003

CLINICAL INFORMATION
CD- 41147608487

PHYSICIAN ID.	PATIENT ID.
PEASANT J	182373

ACCOUNT: Staton Correctional Facility
Prison Health Services
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

	TEST	RESULT		LIMITS	LAB
	CMP12+LP+TP+TSH+6AC+CBC/D/Plt				
	Chemistries				YX
	Glucose, Serum	78	mg/dL	65 - 99	YX
	Uric Acid, Serum	5.9	mg/dL	2.4 - 8.2	YX
	BUN	10	mg/dL	5 - 26	YX
	Creatinine, Serum	1.1	mg/dL	0.5 - 1.5	YX
	BUN/Creatinine Ratio	9		8 - 27	
	Sodium, Serum	140	mmol/L	135 - 148	YX
	Potassium, Serum	5.0	mmol/L	3.5 - 5.5	YX
	Chloride, Serum	103	mmol/L	96 - 109	YX
	Calcium, Serum	9.4	mg/dL	8.5 - 10.6	YX
	Phosphorus, Serum	3.0	mg/dL	2.5 - 4.5	YX
	Protein, Total, Serum	8.1	g/dL	6.0 - 8.5	YX
	Albumin, Serum	4.6	g/dL	3.5 - 5.5	YX
	Globulin, Total	3.5	g/dL	1.5 - 4.5	
	A/G Ratio	1.3		1.1 - 2.5	
	Bilirubin, Total	0.8	mg/dL	0.1 - 1.2	YX
	Alkaline Phosphatase, Serum	99	IU/L	25 - 150	YX
	LDH	151	IU/L	100 - 250	YX
	AST (SGOT)	20	IU/L	0 - 40	YX
	ALT (SGPT)	28	IU/L	0 - 55	YX
	GGT	17	IU/L	0 - 65	YX
	Iron, Serum	150	ug/dL	40 - 155	YX
					YX
	Lipids				YX
	Cholesterol, Total	188	mg/dL	100 - 199	YX
	Triglycerides	52	mg/dL	0 - 149	YX
	HDL Cholesterol	44	mg/dL	40 - 59	YX
	VLDL Cholesterol Cal	10	mg/dL	5 - 40	
>	LDL Cholesterol Calc	134 H	mg/dL	0 - 99	
	Comment				YX
	If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.				
	T. Chol/HDL Ratio	4.3	ratio units	0.0 - 5.0	
	Estimated CHD Risk	0.8	times avg.	0.0 - 1.0	

12/16/06

T. Chol/HDL Ratio

	Men	Women
1/2 Avg.Risk	3.4	3.3
Avg.Risk	5.0	4.4
2X Avg.Risk	9.6	7.1

LabCorp Laboratory Corporation of America
LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000
Phone: 334-263-5745

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
343-684-3278-0	S	YX	COMPLETE	Page #: 2

ADDITIONAL INFORMATION

ECC FASTING: Y
DOB: [redacted]

PATIENT NAME	SEX	AGE(YR./MOS.)
PUGH,CEDRIC	M	30 / 2

PT. ADD.:

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
12/08/2005	12:20	12/09/2005	12/10/2005	8:27	2003

CLINICAL INFORMATION
CD- 41147608487

PHYSICIAN ID.	PATIENT ID.
PEASANT J	182373

ACCOUNT: Staton Correctional Facility
Prison Health Services
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

TEST	RESULT		LIMITS	LAB
3X Avg.Risk	23.4		11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

				YX
Thyroid				YX
TSH	0.368	uIU/mL	0.350 - 5.500	MB
Thyroxine (T4)	8.5	ug/dL	4.5 - 12.0	MB
T3 Uptake	31	%	24 - 39	MB
Free Thyroxine Index	2.6		1.2 - 4.9	
				YX
CBC, Platelet Ct, and Diff				YX
White Blood Cell(WBC)Count	5.7	x10E3/uL	4.0 - 10.5	YX
Red Blood Cell (RBC) Count	5.20	x10E6/uL	4.10 - 5.60	YX
Hemoglobin	15.6	g/dL	12.5 - 17.0	YX
Hematocrit	44.6	%	36.0 - 50.0	YX
MCV	86	fL	80 - 98	YX
MCH	30.0	pg	27.0 - 34.0	YX
MCHC	35.0	g/dL	32.0 - 36.0	YX
RDW	14.2	%	11.7 - 15.0	YX
Platelets	266	x10E3/uL	140 - 415	YX
Neutrophils	49	%	40 - 74	YX
Lymphs	40	%	14 - 46	YX
Monocytes	8	%	4 - 13	YX
Eos	1	%	0 - 7	YX
Basos	2	%	0 - 3	YX
Neutrophils (Absolute)	2.8	x10E3/uL	1.8 - 7.8	YX
Lymphs (Absolute)	2.3	x10E3/uL	0.7 - 4.5	YX
Monocytes(Absolute)	0.5	x10E3/uL	0.1 - 1.0	YX
Eos (Absolute)	0.1	x10E3/uL	0.0 - 0.4	YX
Baso (Absolute)	0.1	x10E3/uL	0.0 - 0.2	YX

LAB: MB LabCorp Birmingham DIRECTOR: John Elgin N MD
1801 First Avenue South, Birmingham, AL 35233-0000

LAB: YX LabCorp Montgomery Hull DIRECTOR: Alton Sturtevant B PhD

LabCorp Laboratory Corporation of America
LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000
Phone: 334-263-5745

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
343-684-3278-0	S	YX	COMPLETE	Page #: 3

ADDITIONAL INFORMATION

ECC FASTING: Y
DOB: [redacted]

PATIENT NAME	SEX	AGE(YR./MOS.)
PUGH,CEDRIC	M	30 / 2

PT. ADD.:

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
12/08/2005	12:20	12/09/2005	12/10/2005	8:27	2003

CLINICAL INFORMATION
CD- 41147608487

PHYSICIAN ID.	PATIENT ID.
PEASANT J	182373

ACCOUNT: Staton Correctional Facility
Prison Health Services
2690 Marion Spillway Road
Elmore AL 36205-0000
ACCOUNT NUMBER: 01308900

TEST	RESULT	LIMITS	LAB

543 Hull Street, Montgomery, AL 36104-0000

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

DATE OF REPORT: 10/28/2005
TIME OF REPORT: 10:16 AM

ACCESSION NO.	NAME	FACILITY
16/182373	CEDRIC PUGH	ECC

DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	TIME RECEIVED
10/12/05	8:30 AM	10/27/05	8:30 AM

Test Name	Result	Out of Range	Reference Range
HIV ANTIBODY	NEG		NEGATIVE (NEG)
RPR	NR		NON-REACTIVE (NR)
URINALYSIS			
PROTEIN	NT		NEGATIVE (NEG)
GLUCOSE	NT		NEGATIVE (NEG)
KETONES	NT		NEGATIVE (NEG)
BILIRUBIN	NT		NEGATIVE (NEG)
BLOOD	NT		< 5 RBC/MCL (NEG)
NITRITE	NT		NEGATIVE (NEG)
UROBILINOGEN	NT		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NT		NEGATIVE (NEG)

* NT = Not Tested

Comment: Results may be unreliable due to age of specimen

11-7-05

WAYNE D. MERCER, PHD
LABORATORY DIRECTOR

CLIA ID NO. 01D0706289

Specimen #	Type	Primary Lab	Report Status

Additional Information

Clinical Information

Physician ID	Patient ID

Patient Name	Sex	Age (Yrs/Mos)

Patient Address

Account

Date Collected	Date Entered	Date Reported	

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Chemistries					
Glucose, Serum	97		mg/dL	65 - 99	
Uric Acid, Serum	5.6		mg/dL	3.4 - 7.2	MB
BUN	9		mg/dL	6 - 24	MB
Creatinine, Serum	1.1		mg/dL	0.57 - 1.00	MB
BUN/Creatinine Ratio	8	Low		9 - 20	
Sodium, Serum	142		mmol/L	134 - 144	MB
Potassium, Serum	4.5		mmol/L	3.5 - 5.2	MB
Chloride, Serum	104		mmol/L	96 - 106	MB
Calcium, Serum	9.3		mg/dL	8.7 - 10.2	MB
Phosphorus, Serum	3.8		mg/dL	2.8 - 4.5	MB
Protein, Total, Serum	7.1		g/dL	6.0 - 8.5	MB
Albumin, Serum	4.7		g/dL	3.5 - 5.5	MB
Globulin, Total	3.0		g/dL	1.5 - 4.5	
A/G Ratio	1.6			1.1 - 2.5	
Bilirubin, Total	0.5		mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	90		IU/L	25 - 150	MB
LDH	140		IU/L	100 - 250	MB
AST (SGOT)	16		IU/L	0 - 40	MB
ALT (SGPT)	20		IU/L	0 - 40	MB
GGT	16		IU/L	0 - 65	MB
Iron, Serum	69		ug/dL	40 - 155	MB
					MB
Lipids					MB
Cholesterol, Total	179		mg/dL	100 - 199	MB
Triglycerides	97		mg/dL	0 - 149	MB
HDL Cholesterol	43		mg/dL	40 - 59	MB
VLDL Cholesterol Cal	17		mg/dL	5 - 40	
LDL Cholesterol Calc	119	High	mg/dL	0 - 99	
Comment					MB

If initial LDL-cholesterol result is >100 mg/dL, assess for CHD Risk Factors and refer to the ATP-III table below.

Risk Category	LDL Goal (mg/dL)	LDL Level (mg/dL) at which to Initiate Therapeutic Lifestyle Changes (TLC)	LDL Level (mg/dL) at which to Consider Drug Therapy
CHD	<100	>100	>or=130
CHD Risk Factors	<130	>or=130	>or=130
0-1 Risk Factors	<160	>or=160	>or=190

Chol/HDL Ratio	4.2	Ratio units	0.0 - 5.0
Estimated CHD Risk	0.7	times avg.	0.0 - 1.0

Chol/HDL Ratio
Risk Values
1/2 Avg. Risk 3.3

FINAL

REPORT

Specimen # | Type | Primary Lab | Report Status

Additional Information

Clinical Information

Physician ID | Patient ID

Patient Name | Sex | Age (Yrs/Mos)

Patient Address

Account

Date Collected | Date Entered | Date Reported

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
				2X Avg.Risk 3.6 7.1	
				3X Avg.Risk 23.4 11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

Thyroid				
TSH	0.411	uIU/mL	0.350 - 5.500	
Thyroxine (T4)	8.1	ug/dL	4.5 - 12.0	
T3 Uptake	31	%	24 - 39	
Free Thyroxine Index	2.5		1.2 - 4.9	
CBC, Platelet Ct, and Diff				
White Blood Cell (WBC) Count	4.8	x10E3/uL	4.0 - 10.5	
Red Blood Cell (RBC) Count	5.15	x10E6/uL	4.10 - 5.60	
Hemoglobin	14.5	g/dL	12.5 - 17.0	
Hematocrit	44.1	%	36.0 - 50.0	
MCV	86	fL	80 - 98	
MCH	28.1	pg	27.0 - 34.0	
MCHC	32.9	g/dL	32.0 - 36.0	
RDW	13.1	%	11.7 - 15.4	
Platelets	233	x10E3/uL	140 - 415	
Neutrophils	51	%	40 - 74	
Lymphs	40	%	14 - 46	
Monocytes	7	%	4 - 12	
Eos	1	%	0 - 7	
Basos	1	%	0 - 3	
Neutrophils (Absolute)	2.4	x10E3/uL	1.8 - 7.8	
Lymphs (Absolute)	1.9	x10E3/uL	0.7 - 4.5	
Monocytes(Absolute)	0.3	x10E3/uL	0.1 - 1.0	
Eos (Absolute)	0.0	x10E3/uL	0.0 - 0.4	
Baso (Absolute)	0.0	x10E3/uL	0.0 - 0.2	
Urinalysis, Routine				
Urinalysis Gross Exam				
Specific Gravity	1.025		1.005 - 1.030	
pH	5.5		5.0 - 7.5	
Urine Color	Yellow		Yellow	
Appearance	Clear		Clear	
Ket. Esterase	Negative		Negative	
Protein	Negative		Negative/Trace	
Glucose	Negative		Negative	
Ketones	Negative		Negative	
Occult Bl.	Negative		Negative	

FINAL

REPORT

pugh,cedric
ID: 182373

05/31/2005 9:43:04

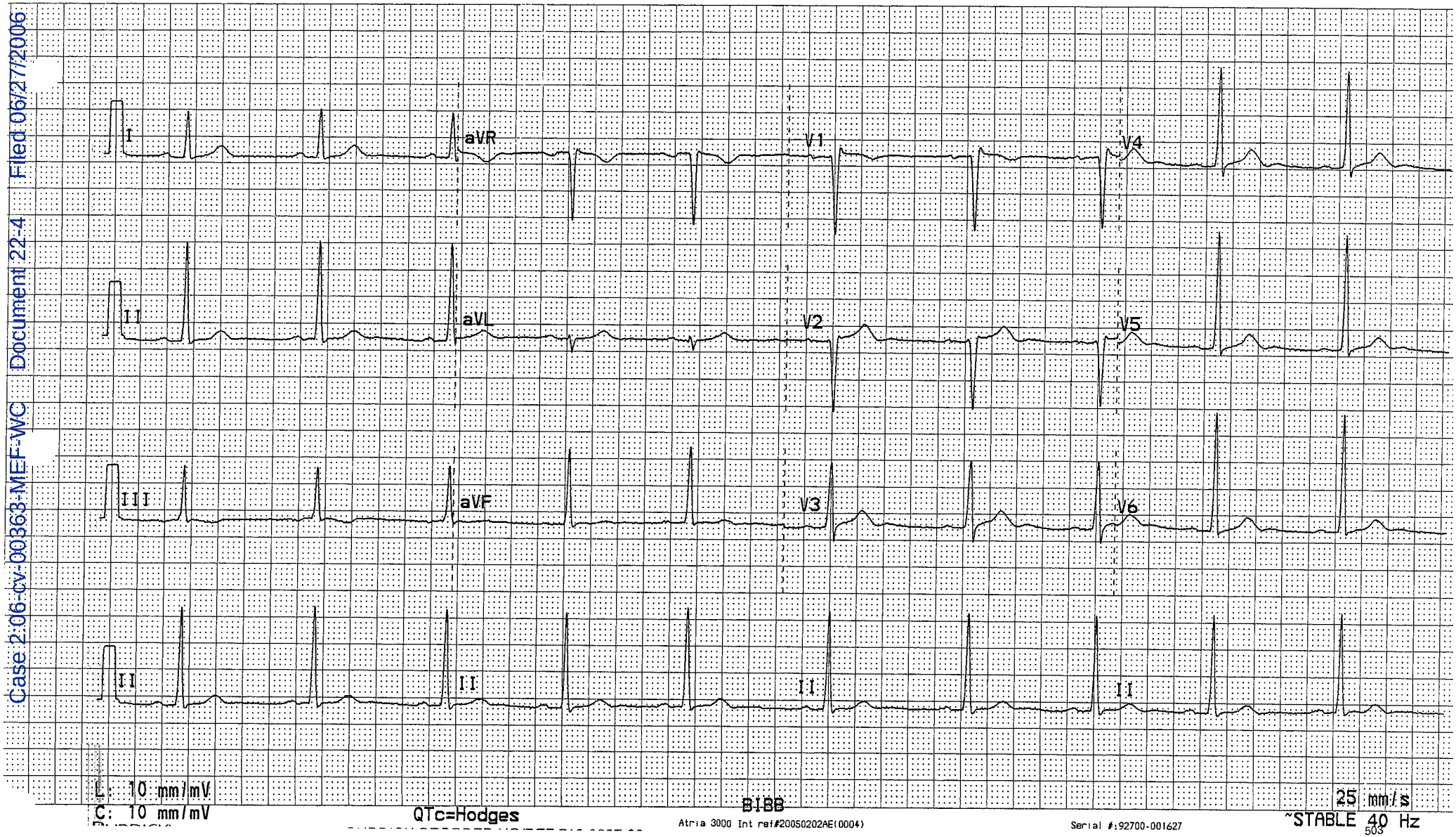
D.O.B.: [redacted] 29 YEARS
MALE
Meds:
Class:
Dr: hamby
Tech: dunnican

Vent. Rate:	61 bpm
RR Interval:	968 ms
PR Interval:	172 ms
QRS Duration:	98 ms
QT Interval:	392 ms
QTc Interval:	393 ms
QT Dispersion:	32 ms
P-R-T AXIS:	5° 64° 9°

SINUS RHYTHM
rSr' pattern in V1 or V2
PROBABLE NORMAL VARIANT

Summary: NORMAL ECG

* Unconfirmed Analysis



HCX

HEALTHCARE CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

Name: J. B. J. CEDRIC

State ID No: 182373

DOB: [redacted]

INSTITUTION: Elmore

Race: B Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Peasant	3-14-06				

HISTORY/DIAGNOSIS:

410 A.B.N

X-RAY REQUEST

	ABDOMEN/KUB	✓	FINGERS (R) MI DIG		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

Pugh

REPORT

RIGHT MIDDLE FINGER: There is evidence of fracture of the distal tuft without significant displacement of fracture fragments.

IMPRESSION: DISTAL TUFT FRACTURE.

D & T: 03-15-06 Thomas J. Payne, III, M.D./rr Board Certified Radiologist (Signature on file)

CRNP 4/12/06 1130

CM KT

X-RAY TECHNOLOGIST'S NAME (PRINT) | X-RAY TECHNOLOGIST'S SIGNATURE | DATE THAT EXAM PERFORMED

HCX

HEALTHCARE CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: Elmore

Name: Pugh, Cedric

State ID No.: 182373

DOB: [redacted]

Race: B Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Dr. Bessant	2/27/06	750	X		

HISTORY/DIAGNOSIS:

R/O Fx Right Hand / 3rd finger

X-RAY REQUEST

	ABDOMEN/KUB		FINGERS		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE	X	HAND Right		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

Pugh

REPORT

RIGHT MIDDLE FINGER: There is mild deformity of the distal phalanx of the right middle finger. This may be due to old trauma but an acute fracture cannot be completely excluded. Clinical correlation and follow up are suggested.

D: & T: 03-02-06 Howard P. Schiele, M.D./jhi Board Certified Radiologist (Signature on file)

3-3-06

J. Kerby RT

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

2-27-06

DATE, TIME EXAM PERFORMED

HCX

HEALTHCARE CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

Name: Pugh Cedric

State ID No.: 182375

DOB: [redacted]

INSTITUTION: BIBB

Race: B Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
CRNP Hambry	5-18-05		X		

HISTORY/DIAGNOSIS:

(1) (R) elbow – Pain after lifting wghts
(2) LS spine – Pain going to left leg
(3) CXR – HTN

X-RAY REQUEST

	ABDOMEN/KUB		FINGERS		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANGLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
X	CERVICAL SPINE (LS)		HIP		PELVIS		THORACIC SPINE
X	CHEST PA / [illegible]		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN/SELLA TURCICA	X	LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
X	ELBOW (Right)		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

REPORT

Pugh

RIGHT ELBOW: The examination shows no evidence of recent fracture or other significant bony abnormality.
IMPRESSION: NEGATIVE STUDY.

JW

Chest: The heart is not enlarged. The lungs are clear.
IMPRESSION: THERE IS NO EVIDENCE OF ACTIVE CARDIOPULMONARY DISEASE.

LUMBAR SPINE: The vertebrae are well aligned and show no evidence of any fracture or any destructive bone disease.
IMPRESSION: NORMAL STUDY.

D: & T: 05-20-05 Thomas J. Payne, III, M.D./jhi Board Certified Radiologist (Signature on file)

J. Kubetz RT

X-RAY TECHNOLOGIST'S NAME (PRINT) — X-RAY TECHNOLOGIST'S SIGNATURE

5-19-05

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT) — RADIOLOGIST'S SIGNATURE — DATE SIGNED

WHITE CHART COPY: CANARY

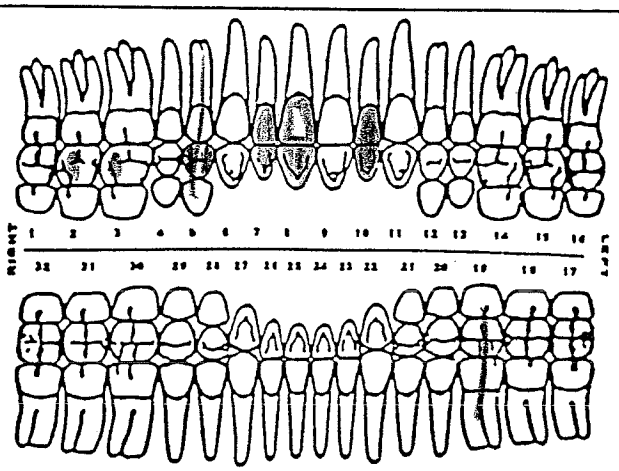
SERVICES RENDERED

DATE	TOOTH	SURFACE	DENTAL SERVICES PROVIDED
11-26-97			Dental Screen. Scheduled Appt January 7th (initials)
2-19-98	5	NRC	2 carps 2% x/lo 1:100,000 Ep used in buccal + palatal infiltration; Simple forcep ext. #5; Oral POI given; Meds given; RTR for pp (signature)
4-2-99	32		Appt scheduled April 13 (S. Martin) Gums swollen.
4-13-99	32	Ext	NRC Rx 1.8cc 2% lido c epi (signature)
			POI Meds
8/27/99			Dental placed. (signature)
12-3-01			Sick call - Pt to RTC on 12-6-01 for ext 30. (signature)
12-17-01			IRM c ANEST. #2+3. Do EXTS if PAIN RECURS (signature)
6/17/02			Gingival inflammation [illegible]
			14-15 area. 1.8cc [illegible]
			[illegible]. Refer to [illegible]
			ext of malpositioned #13. (initials)
9/4/02			Pt. signed [illegible] for possible ext #13 (initials)
9-22-03	3		Deep DOL - [illegible] (2) [illegible]
12-22-04	14	Ext	~~Buccal envelope flap~~ 72mg lidocaine c .036mg epi (signature)
			Buccal envelope flap #4 [illegible] c #150 POI + meds (signature)
10-4-05	21		[illegible] Pt presented [illegible]
			c/c "My tooth is loose and it [illegible]." PA of #21 was
			taken. LOE revealed #21 - Severe alveolar
			bone loss [illegible]
			[illegible] #21 - Single
			Ext 2% lido [illegible] (1.8cc x 1.0cc)
			POI [illegible] Rx Motrin 600mg
			tid x 3 days (signature)
3/23/06	30		[illegible] PA of #30 [illegible]
			#30 [illegible] 2% lido [illegible] 1.8cc
			x1) POI [illegible] (signature)

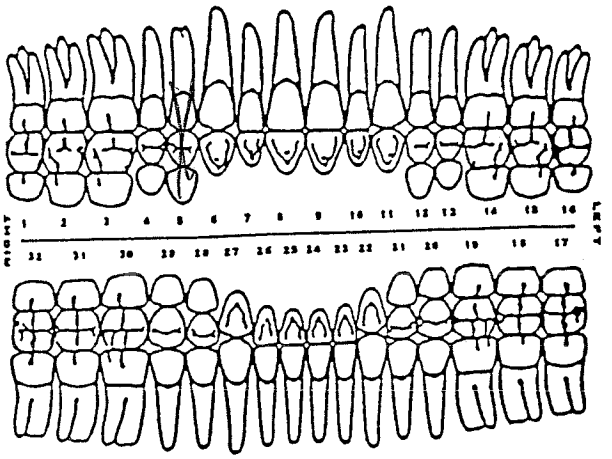
CORRECTIONAL MEDICAL SERVICES
DENTAL TREATMENT RECORD

NAME: PUGH, CEDRIC	ID#: 182373	RACE: B	DOB: [redacted]

DENTAL EXAMINATION



RESTORATION AND TREATMENTS



Date of Initial Examination:	8-20-97
Initial Classification:	6-2-00
Oral Pathology:	8/27/01
Gingivitis	
Vincent's Infection	
Stomatis	
Other Findings	
Occlusion	
Roentgenograms:	
Periapical	
Bitewing	
Panarex	

TOOTH	PRIORITY LIST

HEALTH QUESTIONNAIRE	YES	NO		YES	NO
Are you in good health?	✓		Acquired Immune Deficiency (AIDS/HIV)?		✓
Allergies		✓	Gastrointestinal disorders		✓
Anemia		✓	Glaucoma		✓
Asthma or other respiratory problems		✓	Heart disease or murmur		✓
Blood pressure conditions		✓	Hepatitis		✓
Diabetes		✓	Kidney problems		✓
Epilepsy		✓	Reactions to anesthetics or medications		✓
Excessive bleeding after surgery		✓	Rheumatic fever		✓
Fainting		✓	Taking any medication		✓
Pregnant?		✓	Thyroid conditions		✓
Tuberculosis		✓	Other conditions		✓

PRISON
HEALTH
SERVICES
INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Cedric Pugh **AIS #:** 182573

1. I agree to having dental x-rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

Cedric Pugh
Patient's Signature

3-23-06
Date

Dentist's Signature

3-23-06
Date

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Cedric Pugh Date of Request: 1-24-06
ID # 182373 Date of Birth: [redacted] Location: B2-146-B
Nature of problem or request: I'm requesting to inform that, I sign up for sick call to see the dentist about 2 month ago, and still hadn't seen the dentist yet. My 3 dollar was remove off my account and I hadn't sign anything for it to be remove.

Cedric Pugh
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 1/25/06
Time: 2200
Receiving Nurse Intials: JM
Dental

(S)ubjective: charged and not seen

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____
Dental screening

(A)ssessment: Request Renewed

(P)lan: Saw Dentist 10-4-05 - Last time charged by Dental - Signed up for filling and placed on list. On filling list Thankyou

Refer to: MD/PA Mental Health (Dental) Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Anne Hartt DA
SIGNATURE AND TITLE

PRISON
HEALTH
SERVICES
INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Cedric Pugh **AIS #:** 182773

1. I agree to having dental x-rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

Cedric Pugh
Patient's Signature

3-23-06
Date

Dentist's Signature

3-23-06
Date

PRISON HEALTH SERVICES INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR ORAL SURGERY OR EXTRACTION

Patient Name Cedric Pugh AIS# 182373

1. I understand that there are risks, and possible complications of oral surgery including swelling, bleeding, pain, loss of tooth parts or fillings, bone fragments, sinus involvement, infection, jaw fracture, temporary or permanent numbness or tingling of the lips, tongue, skin, gums, cheek or teeth. Some complications may require further treatment and or surgery.
2. I consent to the use of local anesthetics or other medications and that there are possible side effects, including allergic reactions and these have been explained to me.
3. I have had the opportunity to ask questions which have been answered to my satisfaction.
4. I understand there is no guarantee of success or permanence of the treatment.
5. I authorize the disposal of any tissues, which, in the course of treatment, may be removed.

SPECIFIC TREATMENT

Tooth Number	Procedure	Date
21	Extraction	10-4-05

Cedric Pugh
Patient's Signature

10-4-05
Date

Dentist's Signature

10-4-05
Date

PHS

PRISON
HEALTH
SERVICES
INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Cedric Pugh **AIS #:** 182373

1. I agree to having dental x-rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

Cedric Pugh
Patient's Signature

10-4-05
Date

Dentist's Signature

10/4/05
Date

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Cedric Pugh Date of Request: 9-30-05
ID # 182373 Date of Birth: [redacted] Location: A2-65-TOP
Nature of problem or request: I'm requesting to see the dentist, to get A tooth pull SOON AS possible.
Thank You

Cedric Pugh
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 10-1-05
Time: 2100
Receiving Nurse Intials SN

Dental

(S)ubjective: Tooth pulled

(O)bjective **(V/S):** **T:** **P:** **R:** **BP:** **WT:**
Dental screening

(A)ssessment: Request reviewed

(P)lan: Apt made Watch Newsletter
Thank you

Refer to: MD/PA Mental Health (Dental) Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Anne Hartt DN
SIGNATURE AND TITLE

NaphCare

HEALTH SERVICES REQUEST FORM

Print Name: Cedric Pugh Date of Request: 12/2/01

ID#: 182373 Date of Birth: [redacted] Housing Location: C2-29-Top

Nature of problem or request: I'm requesting to see the doctor to get a tooth pull.

Thank You.

Cedric Pugh

Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

****

HEALTH CARE DOCUMENTATION

Subjective: " My back tooth is bothering me. "

Objective: BP _____ P _____ R _____ T _____

± 30

broken - toothache

Assessment:

Alteration to Comfort

Plan:

RTC to RTC on 12-6-01

for ext 30

Refer to: ___ PA/Physician ___ Mental Health ~~X~~ Dental

[illegible] Title: Dental Date: 12/5/01 Time: ____

INMATE REQUEST SLIP

Name Cedric Pugh Quarters _____ Date 3/31/99

AIS # 182373

( ) Telephone Call ( ) Custody Change ( ) Personal Problem

( ) Special Visit ( ) Time Sheet (✓) Other _____

Briefly Outline Your Request - Then Drop In Mail Box

I'm writing To see when can I see A Doctor to pull My wisdom TeeTH. I CAN'T even eat ON ONE side of My MOUTH AT All or sleep AT Night.

Do Not Write Below This Line - **For Reply Only**

"Ibuprofen real bad" started Tues. I took Tylenol. Didn't help".

E32 - gums swollen tooth is erupting through.

4-13-99

Approved Denied Pay Phone Collect Call

Request Directed To: (Check One)

( ) Warden ( ) Deputy Warden ( ) Captain

( ) Classification Supervisor ( ) Legal Officer - Notary Public ( ) Record Office

N176

NaphCare

Health Services Request Form

Print Name Cedric Pugh Date of Request 6/14/02

ID No. 182393 Date of Birth [redacted] Housing Location G3-25-Top

Nature of problem or request I am having A bad tooth ear, AND I can't sleep or eat on this, So I Need to see A dentist seen as possible To get it pulled. Thank you.

Sign here for consent to be treated by health staff for the condition described above.

Place this slip in Medical Box or designated area
DO NOT WRITE BELOW THIS LINE

JUN '17

Health Care Documentation

Subjective S/C upper back tooth bothers him for cold air and water to hit it - has been hurting constantly for 3 days. Eats on the other side.

Objective BP_____ P_____ R_____ T_____

Assessment SHCU @ 600

Plan

Dental

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Cedric Pugh Date of Request: 7-8-04
ID # 182373 Date of Birth [redacted] Location: D3-46-ToP
Nature of problem or request: Im requesting to see the dentist. I Need to get my tooth pull soon as possible. THANK You.

Cedric Pugh
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

RECEIVED JUL 11

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Cedric Pugh Date of Request: 6-30-04
ID # 152373 Date of Birth: [redacted] Location: D3-46-70P
Nature of problem or request: I'm requesting to see the dentist to get a tooth pull.

Cedric Pugh
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time: JUN 30 2004
Receiving Nurse Intials: _____

(S)ubjective:

(O)bjective (V/S): T: _____ **P:** _____ **R:** _____ **BP:** _____ **WT:** _____

(A)ssessment:

(P)lan: Appt. 7-6-04 N/S

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )